SEATTLE - KING COUNTY DEPARTMENT OF PUBLIC HEALTH
NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT – PLEASE SIGN BELOW

HIPAA requires that we make the Notice of Privacy Practices available to you. We ask that you sign and date this form. **When you sign and date this form you are agreeing that you were given a copy of the Notice of Privacy Practices. You are not agreeing to what the notice says.**

Usually parents sign for children who are minors (under the age of 18). There is an exception when a minor seeks services for the following: family planning services, sexually transmitted disease testing/treatment, outpatient mental health treatment or outpatient alcohol and drug abuse. Under state law, minors may consent to their own treatment for these services. When this happens, they will be asked to sign this form for themselves.

For more information, please read the attached Notice of Privacy Practices.

CLIENT NAME: _____

The undersigned has received the Notice of Privacy Practices of Seattle-King County Dept. of Public Health.

PATIENT/PATIENT REPRESENTATIVE SIGNATURE **DATE OF SIGNING**

_____ _____

Signature Relationship to patient

Internal use only:

☐ *Check if patient declined to sign* _____ _____

Clerk Initials *Date*

☐ *Check if acknowledgement entered into Signature*

*** * *** This is a permanent part of the health record *** * ***

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT	
Public Health Seattle & King County Privacy Office Seattle & King County Dept. of Public Health 999 Third Avenue – Suite 1200 Seattle, WA 98104 Phone: 206.205.5975 Fax: 206.296.0166	Patient Name: MR #: D.O.B.